General

Guideline Title

WHO recommendations for induction of labour.

Bibliographic Source(s)

World Health Organization (WHO). WHO recommendations for induction of labour. Geneva (Switzerland): World Health Organization (WHO); 2011. 36 p. [31 references]

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

The rating schemes for the quality of the evidence (very low, low, moderate, high) and the strength of the recommendations (weak, strong) are defined at the end of the "Major Recommendations" field.

General Principles Related to the Practice of Induction of Labour

The participants in the technical consultation agreed on the following general statements that apply to all recommendations contained in these guidelines:

- Induction of labour should be performed only when there is a clear medical indication for it and the expected benefits outweigh its potential harms.
- In applying the recommendations, consideration must be given to the actual condition, wishes and preferences of each woman, with emphasis being placed on cervical status, the specific method of induction of labour and associated conditions such as parity and rupture of membranes.
- Induction of labour should be performed with caution since the procedure carries the risk of uterine hyperstimulation and rupture and fetal distress.
- Wherever induction of labour is carried out, facilities should be available for assessing maternal and fetal wellbeing.
- Women receiving oxytocin, misoprostol or other prostaglandins should never be left unattended.
- Failed induction of labour does not necessarily indicate caesarean section.
- Wherever possible, induction of labour should be carried out in facilities where caesarean section can be performed.

Induction of Labour in Specific Circumstances

Induction of Labour in Women at or Beyond Term

Recommendations

1. Induction of labour is recommended for women who are known with certainty to have reached 41 weeks (> 40 weeks + 7 days) of gestation. (Low-quality evidence, Weak recommendation)
2. Induction of labour is not recommended for women with an uncomplicated pregnancy at gestational age less than 41 weeks. (Low-quality evidence, Weak recommendation)

Remarks

1. Recommendation No. 1 above does not apply to settings where the gestational age cannot be estimated reliably.
2. There is insufficient evidence to recommend induction of labour for uncomplicated pregnancies before 41 weeks of pregnancy.

Induction of Labour in Women with Gestational Diabetes

Recommendation

1. If gestational diabetes is the only abnormality, induction of labour before 41 weeks of gestation is not recommended. (Very-low-quality evidence, Weak recommendation)

Remark

1. Participants in the World Health Organization (WHO) technical consultation acknowledged that labour induction may be necessary in some women with diabetes – for example, those with placental insufficiency and uncontrolled diabetes.

Induction of Labour for Suspected Fetal Macrosomia

Recommendation

1. Induction of labour at term is not recommended for suspected fetal macrosomia. (Low-quality evidence, Weak recommendation)

Remark

1. Confirmation of suspected macrosomia is based on reliable determination of fetal age and weight, which requires ultrasound assessments early in pregnancy and then at near term. Considering that in under-resourced settings ultrasound facilities may not be available or accessible to all women, the participants in the technical consultation preferred not to recommend induction of labour for suspected macrosomia, even though they acknowledged that in cases of confirmed macrosomia induction of labour could reduce the incidence of clavicle fracture due to shoulder dystocia.

Induction of Labour in Women with Prelabour Rupture of Membranes at Term

Recommendation

1. Induction of labour is recommended for women with prelabour rupture of membranes at term. (High-quality evidence, Strong recommendation)

Remark

1. Participants in the WHO technical consultation noted that in the trials included in the Cochrane review, induction of labour had been initiated within 24 hours of rupture of membranes. They also noted that oxytocin should be regarded as the first option for induction of labour in women with prelabour rupture of membranes.

Induction of Labour in Women with Uncomplicated Twin Pregnancy at or Near Term

Recommendation

1. None.

Remark

1. The participants in the technical consultation noted that there was insufficient evidence to issue a recommendation on induction of labour in

women with an uncomplicated twin pregnancy at or near term.

Methods of Cervical Ripening and Induction of Labour

Oxytocin for Induction of Labour at Term

Recommendation

1. If prostaglandins are not available, intravenous oxytocin alone should be used for induction of labour. Amniotomy alone is not recommended for induction of labour. (Moderate-quality evidence, Weak recommendation)

Remark

1. Immediately after the initiation of intravenous oxytocin, it is advisable to monitor closely the oxytocin infusion rate, response of the uterus to oxytocin, and fetal heart rate. Specific guidance on how to use oxytocin for induction of labour can be found in the WHO manual *Managing complications in pregnancy and childbirth: a guide for midwives and doctors*.

Misoprostol for Induction of Labour at Term

Recommendations

1. Oral misoprostol (25 µg, 2-hourly) is recommended for induction of labour. (Moderate-quality evidence, Strong recommendation)
2. Vaginal low-dose misoprostol (25 µg, 6-hourly) is recommended for induction of labour. (Moderate-quality evidence, Weak recommendation)
3. Misoprostol is not recommended for women with previous caesarean section. (Low-quality evidence, Strong recommendation)

Remarks

1. Recommendations Nos. 1 and 2 refer to women with a non-scarred uterus.
2. The participants in the technical consultation noted the importance of closer monitoring of the mother and her fetus starting immediately after the administration of misoprostol. The participants noted also that labour induction with misoprostol in women with previous caesarean section had not been included as a priority topic in the process of scoping for the present guidelines. However, the participants felt that it was important to address this issue in these guidelines. The participants noted too that one randomized controlled trial was interrupted at the early recruitment stage due to safety concerns (i.e., occurrence of uterine rupture) and that there were observational studies showing mixed results. The participants placed high value on safety and agreed not to recommend the use of misoprostol for induction of labour in women with a scarred uterus. The panel noted that a method with a low risk of uterine hyperstimulation (e.g., balloon catheter) may be preferred in women with a scarred uterus.

Prostaglandins Other Than Misoprostol for Induction of Labour

Recommendation

1. Low doses of vaginal prostaglandins are recommended for induction of labour. (Moderate-quality evidence, Strong recommendation)

Remarks

1. Prostaglandin preparations other than misoprostol are expensive and may not be a priority for implementation, especially in low- and middle-income countries.
2. When prostaglandins are used, close monitoring of the woman and fetus should begin immediately after administration of the drug.

Mechanical Methods for Induction of Labour

Recommendations

1. Balloon catheter is recommended for induction of labour. (Moderate-quality evidence, Strong recommendation)
2. The combination of balloon catheter plus oxytocin is recommended as an alternative method when prostaglandins (including misoprostol) are not available or are contraindicated. (Low-quality evidence, Weak recommendation)

Remark

1. The participants in the technical consultation noted that when using the balloon catheter for induction of labour it is important to monitor the

woman and her fetus closely once labour is established. They also noted that balloon catheter and vaginal prostaglandins may have similar effectiveness. However, balloon catheter may be preferred for women with scarred uterus, since it is less likely to be associated with hyperstimulation of the uterus.

Misoprostol for Termination of Pregnancy in Women with a Fetal Anomaly or After Intrauterine Fetal Death

Recommendation

1. In the third trimester of pregnancy, in women with a dead or anomalous fetus, oral or vaginal misoprostol are recommended for induction of labour. (Low-quality evidence, Strong recommendation)

Remarks

1. The doses and regimens recommended for use of misoprostol for induction of labour at term also apply to the above recommendation.
2. The participants in the technical consultation considered the risk of tachysystole and hypertonus and uterine rupture to be high during labour induction in women with a fetal anomaly or after fetal death. Hence, the participants noted the importance of close monitoring of the woman once labour is established.
3. The participants noted also that the trials included in the systematic review that provided evidence for the above recommendation included women in the second and third trimesters of pregnancy. The participants re-discussed the body of evidence related to misoprostol for induction of labour at term and found it to be applicable to that section also. Hence, the evidence related to induction of labour at term using misoprostol was downgraded for indirectness when applied to termination of pregnancy in women with a fetal anomaly or after intrauterine fetal death.

Sweeping Membranes for Reducing Formal Induction of Labour

Recommendation

1. Sweeping membranes is recommended for reducing formal induction of labour. (Moderate quality evidence, Strong recommendation)

Remarks

1. The panel acknowledged that maternal discomfort and bleeding associated with the procedure should be balanced with the anticipated benefits. Since the interval between intervention and result (i.e., sweeping membranes and initiation of labour) can be longer than with formal methods of induction of labour, this intervention would be suitable for non-urgent indications for pregnancy termination.
2. Regarding breast stimulation, sexual intercourse and other similar methods of pre-induction of labour, the participants in the technical consultation agreed that there was insufficient evidence for recommending those methods.

Management of Complications of Induction of Labour: Hyperstimulation

Tocolytics for Women with Uterine Hyperstimulation During Induction of Labour

Recommendation

1. Betamimetics are recommended for women with uterine hyperstimulation during induction of labour. (Low-quality evidence, Weak recommendation)

Remark

1. There is insufficient evidence to recommend tocolytics other than betamimetics. The participants in the consultation acknowledged that caution should be exercised in using betamimetics because of their side-effects. Their contraindications (e.g., cardiac diseases) should be respected. The participants noted that various preparations of betamimetics are available in different countries.

Setting for Induction of Labour

Outpatient Induction of Labour for Improving Birth Outcomes

Recommendation

1. Outpatient induction of labour is not recommended for improving birth outcomes. (Low-quality evidence, Weak recommendation)

Remark

1. The participants in the consultation noted that research is ongoing on this issue. They placed a high value on safety issues and choose to recommend against the practice of outpatient induction of labour until new information becomes available.

Definitions:

Quality of Evidence

Grade	Definition
High	Further research is very unlikely to change confidence in the estimate of effect.
Moderate	Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate.
Low	Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate.
Very low	Any estimate of effect is very uncertain

Strength of the Recommendations

By default, the strength of the recommendations was initially aligned with the quality of the evidence (i.e., moderate and high quality of evidence prompted strong recommendations while low and very low quality of evidence prompted weak recommendations)

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Conditions for which induction of labour may be indicated, including:

- Pregnancy beyond term
- Prelabour rupture of membranes at term
- Fetal anomaly or fetal death

Guideline Category

Evaluation

Management

Risk Assessment

Clinical Specialty

Family Practice

Nursing

Obstetrics and Gynecology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Hospitals

Nurses

Physician Assistants

Physicians

Public Health Departments

Guideline Objective(s)

- To provide evidence-based recommendations on selected topics related to induction of labour
- To improve the quality of care and outcomes for pregnant women undergoing induction of labour in under-resourced settings

Target Population

Pregnant women who may need to undergo induction of labour, especially those in under-resourced settings

Note: These guidelines do not cover the process of stimulating the uterus during labour to increase the frequency, duration and strength of contractions (labour augmentation), and are not intended as a comprehensive guide on the management of induction of labour.

Interventions and Practices Considered

1. Induction of labour (as indicated)
2. Cervical ripening and induction of labour
    - Intravenous oxytocin
    - Misoprostol (oral, vaginal)
    - Vaginal prostaglandins
    - Balloon catheter
    - Balloon catheter plus oxytocin
    - Misoprostol (for termination of pregnancy in women with a dead or anomalous fetus)
    - Sweeping membranes
3. Management of hyperstimulation (betamimetics)

Note: Amniotomy alone and outpatient induction of labour were considered but not recommended.

Major Outcomes Considered

- Vaginal delivery not achieved within 24 hours
- Caesarean section rate
- Uterine hyperstimulation with fetal heart rate changes
- Serious neonatal morbidity
- Perinatal death
- Severe maternal morbidity or death
- Postpartum haemorrhage

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Cochrane systematic reviews of randomized controlled trials were the primary source of evidence for the recommendations. Based on the list of selected questions and outcomes, the guideline development group identified the relevant Cochrane systematic reviews and determined whether they needed to be updated. Relevant and possibly relevant Cochrane systematic reviews that were considered to be outdated were updated using their specific standard search strategies. A review was considered to be outdated if the last date of search for new trials was two years old, or if there were relevant studies awaiting assessment, as identified by the standard search procedures of the Cochrane Pregnancy and Childbirth Group. For the outdated reviews, the corresponding review authors were invited to update them. Not all authors were in a position to do that within the set deadline. Hence, the review authors who could comply with the deadline and members of the guideline development group jointly updated the systematic reviews. The search strategies employed to identify the trials and the specific criteria for inclusion and exclusion of the trials are described in the individual systematic reviews.

Number of Source Documents

A total of 18 Cochrane systematic reviews were selected for providing the evidence related to the selected questions.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Quality of Evidence

Grade	Definition
High	Further research is very unlikely to change confidence in the estimate of effect.
Moderate	Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate.
Low	Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate.
Very low	Any estimate of effect is very uncertain

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

The following standard operating procedures were used to process in a consistent manner each systematic review used to extract the evidence for these guidelines. First, the up-to-date Review Manager Software (REVMAN) file was retrieved from the Cochrane Pregnancy and Childbirth Cochrane Group. Next the REVMAN file was customized in order to reflect the priority comparisons and outcomes (comparisons and outcomes not relevant to the guidelines were excluded). The next step was to export the REVMAN file to the Grading of Recommendations Assessment,

Development and Evaluation (GRADE) profiler software and apply the GRADE criteria for critical appraisal to the retrieved scientific evidence. As a final step, evidence profiles (GRADE tables) were prepared for each comparison.

The standardized criteria used in grading the evidence and the GRADE tables are not included in the original guideline document (although table numbers – prefixed with 'EB' – are included for ease of reference): they are being published online separately in a document entitled *Evidence base for WHO recommendations for induction of labour* (see the "Availability of Companion Documents" field). Each GRADE table relates to one specific question or comparison. The evidence presented in the GRADE tables was derived from a larger body of data extracted primarily from Cochrane reviews, which in many cases contained multiple comparisons. In some GRADE tables data are not presented for all priority outcomes. This is because data for those outcomes were not available in the Cochrane reviews. The background data which constitute the basis of the GRADE tables are also not included in this document, but can be made available upon request to researchers interested in finding out how the GRADE tables were constructed.

Methods Used to Formulate the Recommendations

Balance Sheets

Expert Consensus

Expert Consensus (Consensus Development Conference)

Description of Methods Used to Formulate the Recommendations

The present guidelines have been prepared in accordance with the process described in the *WHO Handbook for guideline development* (see the "Availability of Companion Documents" field). In summary, the process included: (i) identification of priority questions and critical outcomes; (ii) retrieval of the evidence; (iii) assessment and synthesis of the evidence; (iv) formulation of recommendations; and (iv) planning for dissemination, implementation, impact evaluation and updating.

First, a guideline development group was constituted, which included staff of the World Health Organization (WHO) Departments of Reproductive Health and Research, and Making Pregnancy Safer and two outside experts. This group drafted a list of questions and outcomes related to induction of labour (see Annex 2 of the original guideline document). Next, via an online survey, WHO consulted a group of international stakeholders (midwives, obstetricians, neonatologists, researchers, experts in research synthesis, experts in health-care programmes, and a member of the Cochrane Consumers and Communication Review Group) to review and prioritize the draft questions and outcomes. The international stakeholders commented on the importance of the drafted questions and outcomes and rated them on a scale of 1 to 9. In this context, a 'critical question or outcome' was defined as a question or outcome that received an average score of 7 or more. Questions and outcomes that scored between 4 and 6 were considered 'important but not critical', while those that scored less than 4 were not considered to be important for the purposes of these guidelines. The international stakeholders were encouraged to revise the questions or suggest new questions and outcomes. The responses to the online survey were reviewed by the guideline development group. The questions and outcomes rated as critical were included in the scope of this document for evidence grading and formulation of recommendations and were further refined in order to make them conform to the PICO format (population, interventions, comparisons, and outcomes).

The guideline development group used the information presented in the Grading of Recommendations Assessment, Development and Evaluation (GRADE) tables to draft the recommendations. In order to review and finalize the draft recommendations and the supporting evidence, a technical consultation was organized at WHO headquarters, in Geneva, Switzerland, on 13–14 April 2010. A subset of the international group of experts that had participated in the initial online consultation and other experts were invited to participate in this consultation. The draft recommendations and supporting documents were provided to the consultation participants in advance of the technical consultation.

The strength of each recommendation was determined by assessing each intervention on the basis of: (i) desirable and undesirable effects; (ii) quality of available evidence; (iii) values and preferences related to interventions in different settings; (iv) cost of options available to health-care workers in different settings; and (v) the perceived likelihood of the recommendation being modified as a result of further research. In general, a high-quality, strong recommendation indicates that further research on that question is not considered to be a priority.

Decision-Making During the Technical Consultation

It was planned that the participants in the technical consultation would discuss each of the recommendations drafted by the guideline development group and aim to arrive at a consensus, which was defined as agreement by the large majority of the participants (three quarters of participants), provided that those who disagreed did not feel strongly about their position. Strong disagreements would be recorded as such in the guidelines. If

the participants are unable to reach a consensus, the disputed recommendation, or any other decision, would be put to a vote. The recommendation or decision would stand if a simple majority (more than half) of the participants vote for it, unless the disagreement relates to a safety concern, in which case the WHO Secretariat may choose not to issue a recommendation at all. WHO staff present at the meeting and other external technical experts involved in the collection and grading of the evidence would not be allowed to vote. If the issue to be voted upon involves primary research or systematic reviews conducted by any of the participants who have declared an academic conflict of interest, the participants in question would be allowed to participate in the discussion, but would not be allowed to vote on it. In addition to the scientific evidence and its quality, applicability issues, costs and other judgements would be taken into consideration in the formulation of the final recommendations.

Rating Scheme for the Strength of the Recommendations

By default, the strength of the recommendations was initially aligned with the quality of the evidence (i.e., moderate and high quality of evidence prompted strong recommendations while low and very low quality of evidence prompted weak recommendations).

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Prior to the technical consultation, the guideline development group had prepared a preliminary document containing the draft recommendations. This document was made available to the participants in the technical consultation about one week before the meeting. The statements in the preliminary document were modified during the meeting itself in line with the participants' deliberations. After the meeting, the World Health Organization (WHO) staff involved with these guidelines worked on the draft document to ensure that it reflected accurately the deliberations and decisions of the participants. This revised version was sent electronically back to the participants in the technical consultation for their approval. The comments and feedback received from the participants were incorporated into the document and that version of the document was then sent for external critical appraisal and peer review by a consumer representative and an expert in induction of labour. The external peer reviewers were asked to review the document with regard to its editorial aspects, presentation, wording, inclusion of consumers' views, scoping and the relevance of the recommendations to developing countries. Inputs received from the peer reviewers were carefully evaluated by the guideline development group and the suggestions considered as relevant were included in the document. The concerned WHO staff refrained from making any substantive changes to the scoping (e.g., further expansion of the guideline scoping) of the guidelines or the recommendations agreed upon during the technical consultation.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Improved quality of care and outcomes for pregnant women undergoing induction of labour in under-resourced settings

Potential Harms

- During induction of labour, the woman has restricted mobility and the procedure itself can cause discomfort to her. To avoid potential risks associated with the procedure, the woman and her baby need to be monitored closely. This can strain the limited health-care resources in under-resourced settings. In addition, the intervention affects the natural process of pregnancy and labour and may be associated with increased risks of complications, especially bleeding, caesarean section, uterine hyperstimulation and rupture, fetal distress, and other adverse outcomes.
- Caution should be exercised in using betamimetics because of their side-effects.

Contraindications

Contraindications

Cardiac diseases are a contraindication to use of betamimetics.

Qualifying Statements

Qualifying Statements

- The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city, or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.
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- These guidelines are not intended as a comprehensive guide on the management of induction of labour.

Implementation of the Guideline

Description of Implementation Strategy

The World Health Organization (WHO) Department of Reproductive Health and Research has adopted a formal knowledge-to-action framework for the dissemination, adaptation and implementation of guideline. According to this framework, the present guidelines may be adapted for use in different settings, but in general, any modifications to the recommendations should be limited to weak recommendations and justification for any changes should be made in an explicit and transparent manner.

Guideline Dissemination

The recommendations in these guidelines will be disseminated through a broad network of international partners, including WHO country and regional offices, ministries of health, WHO collaborating centres, other United Nations agencies and nongovernmental organizations. They will also be published on the WHO web site and in the WHO Reproductive Health Library, where it will be accompanied by an independent critical appraisal based on the AGREE (Appraisal of Guidelines Research and Evaluation) instrument (http://www.agreetrust.org/

). In addition, a policy brief aimed at a wide range of policy-makers, programme managers and clinicians will be developed and disseminated through WHO country offices.

Guideline Implementation

The successful introduction into national programmes and health-care services of evidence-based policies related to induction of labour depends on well-planned and participatory consensus-driven processes of adaptation and implementation. The adaptation and implementation processes may include the development or revision of existing national guidelines or protocols based on this document.

The recommendations contained in the present guidelines should be adapted into a locally appropriate document that can meet the specific needs of each country and health service. However, beyond that, a set of interventions should be established to ensure that an enabling environment is created for the use of the recommendations (including, for example, the availability of misoprostol/oxytocin/balloon catheter and monitoring capacity), and that the behaviour of the health-care practitioner changes towards the use evidence-based practices. In this process, the role of local professional societies is important and an all-inclusive and participatory process should be encouraged. The WHO Department of Reproductive Health and Research has published specific guidance on the introduction of WHO's reproductive health guidelines and tools into national programmes.

Refer to Section 7 of the original guideline document for "Applicability Issues," including anticipated impact on the organization of care and resources and monitoring and evaluating the guideline implementation.

Implementation Tools

Audit Criteria/Indicators

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

World Health Organization (WHO). WHO recommendations for induction of labour. Geneva (Switzerland): World Health Organization (WHO); 2011. 36 p. [31 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2011

Guideline Developer(s)

World Health Organization - International Agency

Source(s) of Funding

World Health Organization

United States Agency for International Development (USAID) provided financial support for the work on these guidelines.

Guideline Committee

Guideline Development Group

Composition of Group That Authored the Guideline

Guideline Development Group at the World Health Organization (WHO): Dr Melania Maria Ramos de Amorim, Universidade Federal de Campina Grande, Campina Grande, Brazil; Dr Caroline Fox, Birmingham Women's Hospital, Birmingham, United Kingdom; Dr A. Metin Gülmezoglu, Medical Officer, Department of Reproductive Health and Research, World Health Organization, Geneva, Switzerland; Mr Jitendra Khanna, Technical Officer, Department of Reproductive Health and Research, World Health Organization, Geneva, Switzerland; Dr Matthews Mathai, Medical Officer, Department of Making Pregnancy Safer, World Health Organization, Geneva, Switzerland; Dr João Paulo Souza, Medical Officer, Department of Reproductive Health and Research, World Health Organization, Geneva, Switzerland

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Financial Disclosures/Conflicts of Interest

Before participating in the meeting, all participants in the World Health Organization (WHO) technical consultation (except WHO staff) made a declaration of interest on a standard WHO form. The declarations were reviewed by WHO before the consultation. Dr Justus Hofmeyr, Dr Michel Boulvain, and Dr Andrew Weeks declared that they had conducted primary research and systematic reviews on topics related to induction of labour. None of the participants declared either any commercial conflict of interests or any other interest requiring their exclusion from the meeting.

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available from the World Health Organization Web site .

Print copies: Available from the WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland; Phone: +41 22 791 3264; Fax: +41 22 791 4857; E-mail: bookorders@who.int.

Availability of Companion Documents

The following are available:

- WHO recommendations induction of labor. Evidence base. Geneva (Switzerland): World Health Organization (WHO); 2012. 118 p. Electronic copies: Available in Portable Document Format (PDF) from the World Health Organization (WHO) Web site .
- World Health Organization. WHO handbook for guideline development. Geneva (Switzerland): World Health Organization (WHO); 2012. 56 p. Electronic copies: Available from the WHO Web site .

In addition, process indicators can be found in section 7 of the original guideline document .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on March 22, 2013.

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